Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: WEST HOUSTON MEDICAL CENTER HOLLAWAY & GUMBERT 3701 KIRBY DRIVE SUITE 1288 HOUSTON TX 77098	MFDR Tracking #: M4-06-6430-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: BITUMINOUS CASUALTY CORP. Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "To date, a total of $5,590.00 has been paid by your company with respect to the above referenced charges…Our review of the rules established by the Division show that your company failed to price our client's claim correctly according to these rules." "Our client's UB-92 shows an admitting and principal ICD-9 diagnosis code of '875.1.' DWC Rule 134.401(c)(5) requires claims with primary ICD-9 diagnosis codes that fall in the range '800.0-959.50' be reimbursed at a fair and reasonable rate for the entire admission. Your company appears to have improperly priced this claim using the per-diem reimbursement methodology, **which is inapplicable to claims with ICD-9 primary diagnosis codes as listed in Rule 134.401(c)(5)**."

Requestor's Request for Reconsideration dated July 12, 2005 states "This claim has been identified as being underpaid by$1197.50." [sic]

Amount in Dispute per DWC-60: $23,368.18

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is the completed TWCC-60. Also attached are the EOBs showing this admission is properly paid using the preferred per-diem methodology as a measure of fair and reasonable. While this is coded as a trauma admission, the services actually rendered are no more extensive (and probably less so) than a surgical admission. Accordingly, the per diem method is an appropriate measure of fair and reasonable." "Carrier has properly paid $5,590.00. Requestor's claim of an additional $1,197.00 (total of $6,787.50) is unfounded."

Respondent's Supplemental Response to this Dispute dated July 6, 2006 states "Requestor has acknowledged that the payment at the per diem rate was appropriate for this case. The dispute centers on the allowance for the abdominal CT. Carrier has appropriately paid at the MFG multiplier and based upon usual and customary data as a measure of fair and reasonable. There is not support for the request to be reimbursed 50% of billed charges for the CT."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
3/24/2005 through 3/29/2005	510, 520, W1, W3, W10	Inpatient Surgery Admission	$23,368.18	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 24, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1,

2003, the Division notified the requestor on June 14, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 510-Payment determined.
   - 520-Inpatient Surgical per diem allowance.
   - W1-Workers Compensation state fee schedule adj.
   - W3-Additional payment made on appeal/reconsideration.
   - W10-Payment based on fair & reasonable methodology.
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 875.1. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "To date, a total of $5,590.00 has been paid by your company with respect to the above referenced charges…Our review of the rules established by the Division show that your company failed to price our client's claim correctly according to these rules." "Our client's UB-92 shows an admitting and principal ICD-9 diagnosis code of '875.1.' DWC Rule 134.401(c)(5) requires claims with primary ICD-9 diagnosis codes that fall in the range '800.0-959.50' be reimbursed at a fair and reasonable rate for the entire admission. Your company appears to have improperly priced this claim using the per-diem reimbursement methodology, **which is inapplicable to claims with ICD-9 primary diagnosis codes as listed in Rule 134.401(c)(5)**."
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how additional payment of $23,368.18 would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division

concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		10/27/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		10/27/2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.